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ABSTRACT

Written for migrant nurses, this manual is intended to simplify and speed up the process of entering pertinent medical information onto the Migrant Student Record Transfer System (MSRTS) data base. It is designed to be used in conjunction with the indepth technical information in the National MSRTS Health Users Manual and includes page references to that document. The first section explains in detail the Health Data Entry Form and gives specific directions for completing each section: identifying data, patient history, family history, immunizations, screenings and laboratory tests, and health problems. Sample problem situations and solutions are included. Subsequent chapters provide basic information about the medical record (the output document prepared from the Health Data Entry Form), filing system requirements for migrant student health records, how to handle records when students move, how to make corrections and deletions to the records, and how to handle sensitive data (child abuse, neglect, etc.). The reference and resource section provides: a directory of migrant nurses by parish, codes and abbreviations used in the health records, a glossary of eight terms and acronyms used in MSRTS health records, and ordering information for two medical references. (JHZ)

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FEB 1988

Louisiana MSRTS Manual

Health

Bulletin
1711

Migrant Student Record Transfer System

MIGRANT STUDENT RECORD TRANSFER SYSTEM

LOUISIANA HEALTH MANUAL

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BULLETIN 1711

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FOREWORD

This manual represents the combined efforts of MSRTS Specialists, Migrant Nurses, Technical Assistants, and Data Entry Specialists from throughout the State of Louisiana who were a part of the MSRTS Manual Revision Committee. They truly were the logical authors because of their day to day experiences with the Migrant Student Record Transfer System at local, regional, and State levels. Without the expertise and insight of each one of these people, publication of this informative and comprehensive guide would have been impossible. I gratefully acknowledge the following committee members:

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INTRODUCTION

The migrant nurse is an individual, professionally prepared in both nursing and education who works toward improving, protecting, and maintaining the health of her pupils, their families, and school personnel. Her preparation enables her to provide services for prevention and early detection of health problems and to utilize health experiences for health counseling and health education.

Through an organized program with objectives and goals based on specific guidelines in all areas of health services, the migrant nurse strives to complete the circle of education's total approach; to instill the ideals of self-preservation, of hope; and most importantly, to reinforce feelings of self-worth in each child.

The migrant nurse knows and complies with all State and parish school laws, regulations, and recommendations.

The goal of this manual is to enable migrant nurses and MSRTS specialists throughout the State of Louisiana to enter pertinent medical information onto the Migrant Student Record Transfer System data base with ease.

Our intent is to simplify all record-keeping procedures and to expedite efficient time-management. For further explanations and more indepth technical information, refer directly to the National M.S.R.T.S. Health Users Manual.

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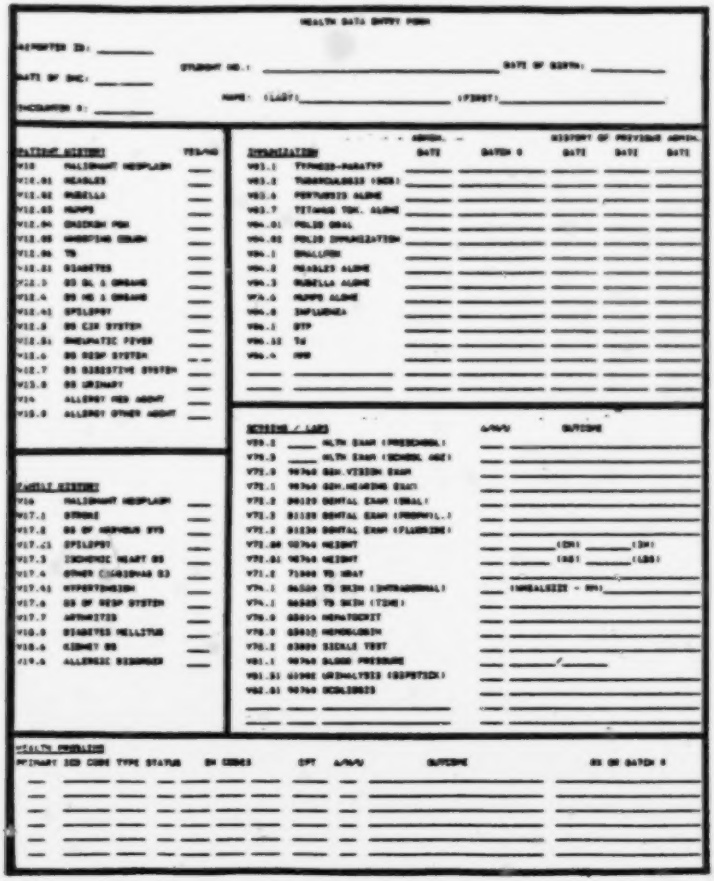
Health
Data Entry Form

SAMPLE

The Health Data Entry Form is the input document and is the only means of reporting medical data about the student.



GUIDELINES

- This form must always be completed in red ink. Accuracy and legibility are important essentials.

- A dated copy must be retained in a pending file until the updated medical record is received and checked.

- All work submitted must be dated using the month and day mailed.

- If you do not receive a medical record within three weeks after sending in the Health Data Entry Form, notify the terminal center at the State migrant office.
  DO NOT RESUBMIT DATA!!!

- In this manual, the problems and solutions are sequentially numbered in the text and correspond with the numbered sections shown in the samples.

IDENTIFYING DATA

This information is used to identify the student for whom the medical service(s) was provided.

HEALTH DATA ENTRY FORM

REPORTER ID: (1)

DATE OF ENC: (2)

ENCOUNTER #: (3)

STUDENT NO.: (4) DATE OF BIRTH: (6)

NAME: (LAST) (5) (FIRST)

The spaces numbered above must be completed correctly before any health data can be entered.

1. Reporter ID: The six letter identification for the parish reporting the information. (Refer to page 39 for a complete list of all parish short ID's.)

2. Date of Encounter: Use the six-digit date (month, day, year) the child was served or the date information was obtained from other resources.

3. Encounter Number: Two alpha characters (the nurse's initials) plus two numbers (in most cases this will be 01) which indicate the number of times the student was seen on the day of encounter. Example: Jane Doe, R.N., would code this section as JD01.

4. Student Number: This is composed of the eight numbers and three alpha characters which identify the student on the data base.

5. Student Name: This will help to identify a student when errors are made in the student number.

6. Date of Birth: This could aid you in identifying students with similar names and backgrounds. This portion is optional.

PATIENT HISTORY

The Patient History section is for recording previous and existing health problems.

PATIENT HISTORY		YES/NO
V10	MALIGNANT NEOPLASM	___
V12.01	MEASLES	___
V12.02	RUBELLA	___
V12.03	MUMPS	___
V12.04	CHICKEN POX	___
V12.05	WHOOPING COUGH	___
V12.06	TB	___
V12.21	DIABETES	___
V12.3	DS BL & ORGANS	___
V12.4	DS NS & ORGANS	___
V12.41	EPILEPSY	___
V12.5	DS CIR SYSTEM	___
V12.51	RHEUMATIC FEVER	___
V12.6	DS RESP SYSTEM	___
V12.7	DS DIGESTIVE SYSTEM	___
V13.0	DS URINARY	___
V14	ALLERGY MED AGENT	___
V15.0	ALLERGY OTHER AGENT	___

- Enter "Y" for "yes" when a condition or disease exists or existed.

- Multiple "no" entries will result in numerous pages of patient data being printed on each record. We prefer that this data <u>not be</u> submitted.

- The Health Problem section is used to record more specific information pertaining to the Patient History section. An example of this use is shown on the next page.

PATIENT HISTORY VIA HEALTH PROBLEMS

Problem: The student has a severe bee sting allergy which could prove to be a serious medical emergency if not known and noted on the student record.

PATIENT HISTORY		YES/NO
V10	MALIGNANT NEOPLASM	
V12.01	MEASLES	
V12.02	RUBELLA	
V12.03	MUMPS	
V12.04	CHICKEN POX	
V12.05	WHOOPING COUGH	
V12.06	TB	
V12.21	DIABETES	
V12.3	DS BL & ORGANS	
V12.4	DS NS & ORGANS	
V12.41	EPILEPSY	
V12.5	DS CIR SYSTEM	
V12.51	RHEUMATIC FEVER	
V12.6	DS RESP SYSTEM	
V12.7	DS DIGESTIVE SYSTEM	
V13.0	DS URINARY	
V14	ALLERGY MED AGENT	
V15.0	ALLERGY OTHER AGENT	Y(1)

Solution:

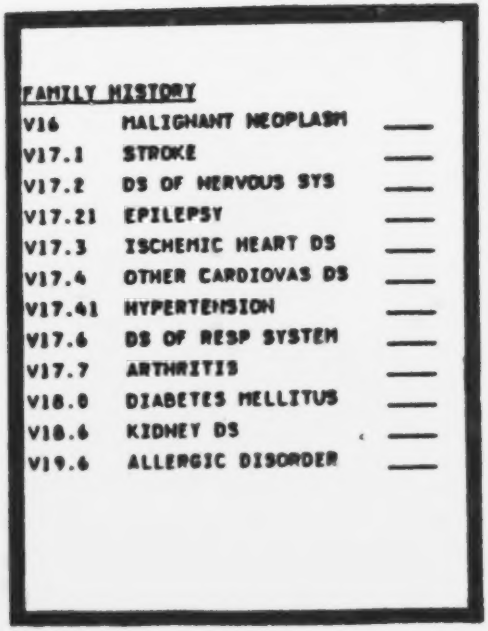
1. Put a "Y" in "allergy other agent" in Patient History section.
   Then go to the Health Problem section.
2. An "X" must be entered in Primary.
3. Identify allergy by specific ICD code number and enter in appropriate column. The ICD code for Bee Sting Allergy is 989.5 which can be found in the ICD codes list.
4. Enter a "C" in Type to indicate a chronic condition.
5. Enter "U" in Status to indicate that the condition is unresolved.
6. Refer to E-H linkage codes and research for appropriate message. In this case, E-H 111 will print the following message: "Insect allergy severe - have plan of action in case of sting."
7. Enter default CPT code 90760 in the CPT column.
8. Enter "U" for undetermined in A/N/U column.
9. Enter a condensed message or brief instruction in Outcome as only 39 characters are allowed. The message in this example is: "Have sting kit available at school."

HEALTH PROBLEMS

PRIMARY	ICD CODE (3)	TYPE (4)	STATUS (5)	EH CODES (6)		CPT (7)	A/N/U (8)	OUTCOME (9)	RX OR BATCH #
X	989.5	C	U	111		90760	U	HAVE STING KIT AVAILABLE AT SCHOOL	

FAMILY HISTORY

The Family History section is for recording previous and current health problems of the student's immediate family.



FAMILY HISTORY		
V16	MALIGHANT NEOPLASM	____
V17.1	STROKE	____
V17.2	DS OF NERVOUS SYS	____
V17.21	EPILEPSY	____
V17.3	ISCHEMIC HEART DS	____
V17.4	OTHER CARDIOVAS DS	____
V17.41	HYPERTENSION	____
V17.6	DS OF RESP SYSTEM	____
V17.7	ARTHRITIS	____
V18.0	DIABETES MELLITUS	____
V18.6	KIDNEY DS	____
V19.6	ALLERGIC DISORDER	____

- Enter "Y" for "yes" when a condition or disease exists or existed.

- Multiple "no" entries will result in numerous pages of patient data being printed on each record. We prefer that this data <u>not be</u> submitted.

IMMUNIZATIONS

This section is for recording the immunizations the student has received to date.

IMMUNIZATION		ADMIN. DATE	BATCH #	HISTORY OF PREVIOUS ADMIN. DATE	DATE	DATE
V03.1	TYPHOID-PARATYP					
V03.2	TUBERCULOSIS (BCG)					
V03.6	PERTUSSIS ALONE					
V03.7	TETANUS TOX. ALONE					
V04.01	POLIO ORAL					
V04.02	POLIO IMMUNIZATION					
V04.1	SMALLPOX					
V04.2	MEASLES ALONE					
V04.3	RUBELLA ALONE					
V04.6	MUMPS ALONE					
V04.8	INFLUENZA					
V06.1	DTP					
V06.12	Td					
V06.4	MMR					

- Six-digit dates which include month, day, and year (MMDDYY) must be used.
- Extra lines are provided to indicate additional immunization dates as required.
- The Batch # portion is optional and does not have to be completed.

Specific examples of coding this section are demonstrated on the following pages.

IMMUNIZATIONS

Problem: The student had a series of DTP shots with dates of 031581, 051781, and 061281. A preschool DTP was administered on 042282; however, the student did not enter school as planned and an additional booster was given on 041583. These immunizations are recorded as shown below:

IMMUNIZATION		ADMIN. DATE	BATCH #	HISTORY OF PREVIOUS ADMIN. DATE	DATE	DATE
V03.1	TYPHOID-PARATYP	(2)		(1)	(1)	(1)
V03.2	TUBERCULOSIS (BCG)					
V03.6	PERTUSSIS ALONE					
V03.7	TETANUS TOX. ALONE					
V04.01	POLIO ORAL					
V04.02	POLIO IMMUNIZATION					
V04.1	SMALLPOX					
V04.2	MEASLES ALONE					
V04.3	RUBELLA ALONE					
V04.6	MUMPS ALONE					
V04.8	INFLUENZA					
V06.1	DTP	042282		031581	051781	061281
V06.12	Td					
V06.4	MMR					
V06.1	(3)	041583				

Solution:

1. Record the first series of dates, sequentially, in the three columns indicated under History of Previous Admin.
2. Record the first booster administered in the Admin. Date column on the same line.
3. Record the most recent booster on the additional line provided by entering the appropriate ICD code and indicating the date in the Admin. Date column. It is not necessary to enter the immunization name as this will be printed automatically.

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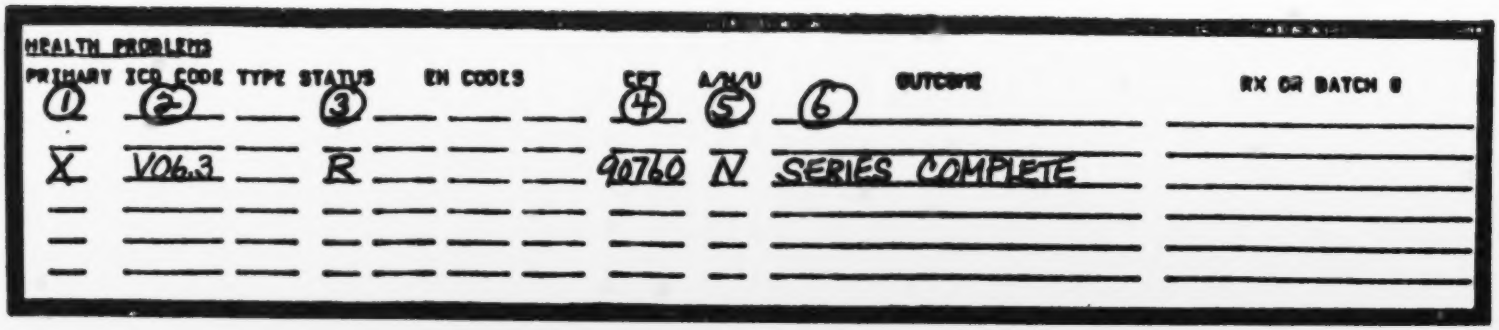
IMMUNIZATIONS VIA HEALTH PROBLEMS

Problem: If dates are not available but student has an MCH 14 card, code as shown below via the Health Problems section. Do not enter anything in the Immunizations section.

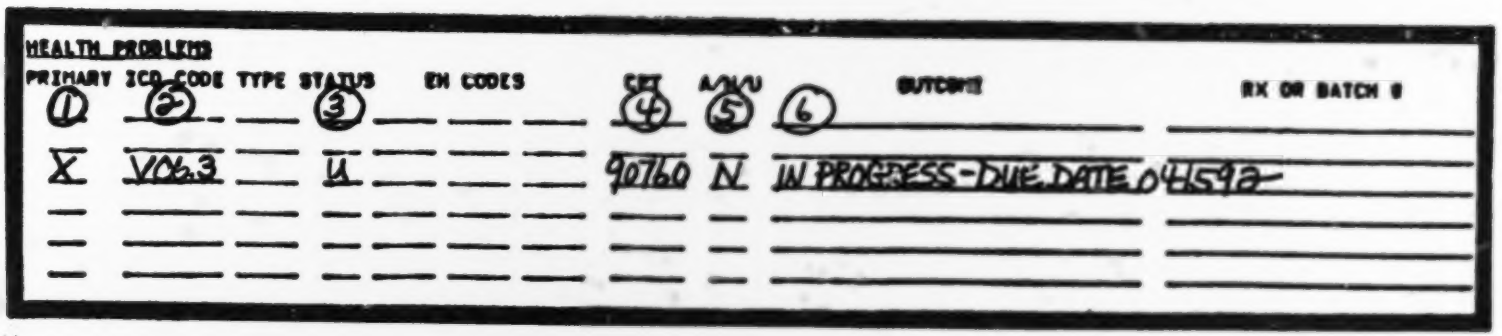


Solution:

1. An "X" is entered in the Primary column.
2. The appropriate ICD Code is entered. Please check ICD codes for accuracy.
3. Status is indicated as "R" for resolved.
4. The default CPT code 90760 is entered.
5. This column is optional. However, if a message is entered in the Outcome column, A/N/U must have an entry. In this case, "N" for normal is used.
6. This column is also optional. If a message is entered it must be brief and contain fewer than 39 characters. "Series complete" is recorded.

IMMUNIZATIONS VIA HEALTH PROBLEMS

Problem: If all dates are not available, and student is still in progress, code as shown below in the Health Problem section.



Solution:

1. An "X" is entered in the Primary column.
2. The appropriate ICD code is entered. Please check ICD codes for accuracy.
3. Status is indicated as "U" for unresolved.
4. The default CPT code 90760 is entered.
5. This column is optional. However, if a message is entered in the Outcome column, A/N/U must have an entry. In this case, "N" for normal is indicated.
6. This column is also optional. If a message is entered it must be brief and contain fewer than 39 characters. "In progress - due date 041592" is entered.

SCREENS/LABS

This section is for recording the screenings, examinations, and laboratory tests the student has received.

SCREENS / LABS			A/N/U	OUTCOME
V20.2	_____	HLTH EXAM (PRESCHOOL)	___	_____
V70.5	_____	HLTH EXAM (SCHOOL AGE)	___	_____
V72.0	90760	GEN.VISION EXAM	___	_____
V72.1	90760	GEN.HEARING EXAM	___	_____
V72.2	D0120	DENTAL EXAM (ORAL)	___	_____
V72.2	D1120	DENTAL EXAM (PROPHYL.)	___	_____
V72.2	D1230	DENTAL EXAM (FLUORIDE)	___	_____
V72.80	90760	HEIGHT	___	_____(CM) _____(IN)
V72.81	90760	WEIGHT	___	_____ (KG) _____(LBS)
V71.2	71000	TB XRAY	___	_____
V74.1	86580	TB SKIN (INTRADERMAL)	___	(WHEALSIZE - MM)_____
V74.1	86585	TB SKIN (TINE)	___	_____
V78.0	85014	HEMATOCRIT	___	_____
V78.0	85018	HEMOGLOBIN	___	_____
V78.2	83020	SICKLE TEST	___	_____
V81.1	90760	BLOOD PRESSURE	___	_____/_____
V81.51	81002	URINALYSIS (DIPSTICK)	___	_____
V82.81	90760	SCOLIOSIS	___	_____
_____	___	_____	___	_____
_____	___	_____	___	_____

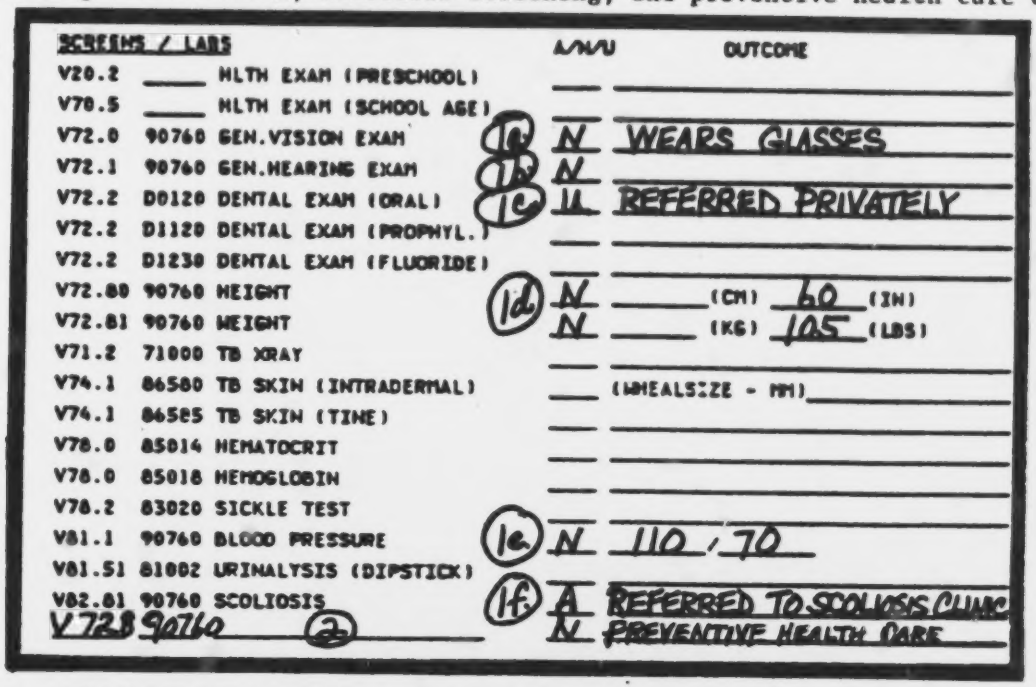
- The findings of the screens/labs are indicated in the A/N/U column as "A" for abnormal, "N" for normal, and "U" for undetermined.

- The Outcome column is used to indicate specific results of screens/labs that are <u>other than normal</u>.

- Extra lines are provided to include screens/labs not indicated on the Health Data Entry Form.

SCREENS/LABS

Problem: The student receives general vision, hearing, and oral dental exams. A height and weight measurement, blood pressure check, scoliosis screening, and preventive health care check are also performed.



SCREENS / LABS			A/N/U	OUTCOME
V20.2	_____	HLTH EXAM (PRESCHOOL)	___	
V70.5	_____	HLTH EXAM (SCHOOL AGE)	___	
V72.0	90760	GEN.VISION EXAM	N	WEARS GLASSES
V72.1	90760	GEN.HEARING EXAM	N	
V72.2	D0120	DENTAL EXAM (ORAL)	U	REFERRED PRIVATELY
V72.2	D1120	DENTAL EXAM (PROPHYL.)	___	
V72.2	D1230	DENTAL EXAM (FLUORIDE)	___	
V72.80	90760	HEIGHT	N	_____ (CM) 60 (IN)
V72.81	90760	WEIGHT	N	_____ (KG) 105 (LBS)
V71.2	71000	TB XRAY	___	
V74.1	86580	TB SKIN (INTRADERMAL)	___	(WHEALSIZE - MM)_____
V74.1	86585	TB SKIN (TINE)	___	
V78.0	85014	HEMATOCRIT	___	
V78.0	85018	HEMOGLOBIN	___	
V78.2	83020	SICKLE TEST	___	
V81.1	90760	BLOOD PRESSURE	N	110/70
V81.51	81002	URINALYSIS (DIPSTICK)	___	
V82.81	90760	SCOLIOSIS	A	REFERRED TO SCOLIOSIS CLINIC
V728	90760	(2)	N	PREVENTIVE HEALTH CARE

Solution:

1. Indicate the results by entering "A" for abnormal, "N" for normal, or "U" for undetermined in the A/N/U column with any brief comments in the Outcome column.
   a. The student wears glasses and has a normal general vision exam with them on.
   b. The general hearing exam also proves to be normal.
   c. The oral dental exam reveals that the student needs a private referral.
   d. The student's height is normal at 60 inches as is a weight of 105 pounds.
   e. The blood pressure check is also normal at 110/70.
   f. The scoliosis check reveals the possibility of some abnormality, and the student is referred to the scoliosis clinic for a further check.
2. A preventive health care check is performed by the nurse. Because there is no line that contains this ICD code, the code is entered in the first column followed by the 90760 default CPT code. The outcome is indicated as "N" and a brief message "preventive health care" appears.

HEALTH PROBLEMS

This area is used to record health problems. As previously shown, this section can also be used to record data from other sections of the Health Data Entry form as needed.

A health problem must be coded in the following manner:

1. An "X" is entered to indicate a Primary condition.
2. The ICD code is entered. Refer to ICD codes list for accuracy.
3. Type is indicated as either "A" for acute or "C" for chronic.
4. Status is indicated as either "R" for resolved or "U" for unresolved.
5. Entering an E-H code is optional as these codes are, in most cases, automatically assigned by the computer based upon the ICD code used. In certain situations, however, this portion may be completed.*
6. A CPT Code is entered to indicate the services provided.
7. Indicate the results of the CPT by using "A" for abnormal, "N" for normal, or "U" for undetermined. This is optional, however, if a message is entered in Outcome, A/N/U must be completed.
8. Indicate the Outcome if desired or known. This portion is also optional; however, use a condensed message or brief instruction as only 39 characters are allowed. If this column has an entry in it, then the previous A/N/U column must be completed.

* See page 39 in National Health Users Manual for additional information.

HEALTH PROBLEMS

Problem: The student is diagnosed as having bacterial pneumonia (bilateral, pneumococcal) and is hospitalized, treated, and released.

HEALTH PROBLEMS

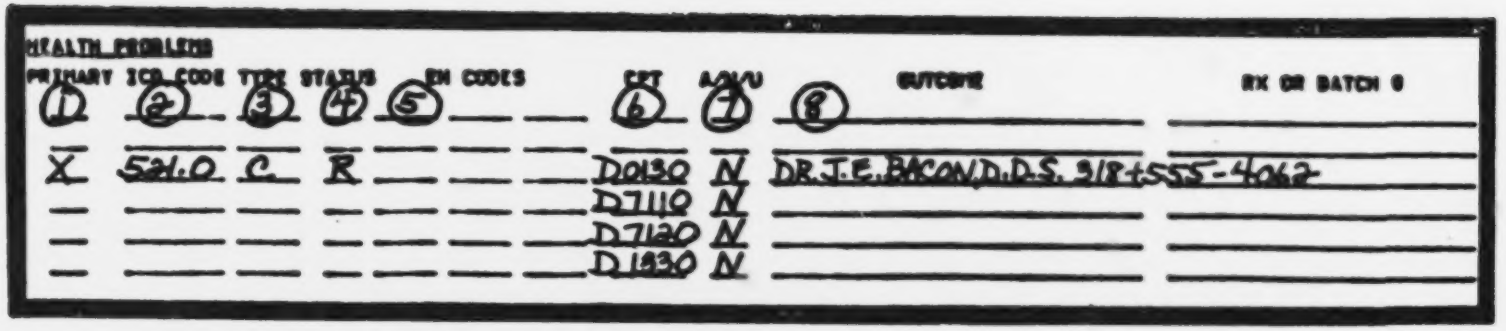
PRIMARY	ICD CODE	TYPE	STATUS	EH CODES			CPT	A/N/U	OUTCOME	RX OR BATCH #
①	②	③	④	⑤			⑥	⑦	⑧	
X	482.9	A	R				90220	N	BATON ROUGE CHARITY	HOSPITAL

Solution:

1. An "X" must be placed in the Primary column.
2. The ICD code for bacterial pneumonia is 482.9 and is entered in the ICD column.
3. The type is indicated with an "A" for an acute condition.
4. The status is indicated as "R" for a condition that has been resolved.
5. No entry needs to be made in the E-H codes columns because E-H code 008 is going to be assigned automatically to this problem by the computer. Refer to page 50, Appendix A, of the National Health Users Manual for the listing of these automatically assigned codes.
6. The CPT code 90220 is used to indicate the treatment received. Refer to page 61, Appendix C, of the National Health Users Manual. CPT 90220 will print the message "Hospital Care, New, Compreh."
7. An "N" is entered in the A/N/U column to indicate a normal response to the treatment rendered.
8. A brief message is provided to indicate the hospital name which is "Baton Rouge Charity Hospital."

HEALTH PROBLEMS

Problem: A student with multiple cavities and pain present goes to a dentist for treatment.


HEALTH PROBLEMS
PRIMARY ICD CODE TYPE STATUS EH CODES CPT A/N/U OUTCOME RX OR BATCH #
1 2 3 4 5 6 7 8
X 521.0 C R D0130 N DR.J.E.BACON,D.D.S. 318+555-4062
D7110 N
D7120 N
D1330 N

Solution:

1. An "X" must be placed in the Primary column.
2. The ICD code for dental caries is 521.0 and is entered in the ICD column. Note: When the same ICD code has several different CPT codes, indicate the ICD code, Type, and Status on the first line of entry only.
3. The type is indicated by entering a "C" for chronic condition.
4. The status is indicated as "R" for resolved.
5. No entry needs to be made in the E-H codes column.
6. Dental CPT codes are used to indicate the various treatments performed. The student had an emergency exam (D0130), an extraction (D7110) with an additional extraction (D7120), and oral hygiene instructions (D1330). They are indicated as shown in the example. Refer to page 77, Appendix E, in the National Health Users Manual for further information.
7. An "N" is entered in the A/N/U column to indicate a normal response to the treatment.
8. A brief message is provided to indicate the dentist's name and phone number. "Dr. J. E. Bacon, D.D.S. 318+555-4062."

MEDICAL RECORD (OUTPUT DOCUMENT)

Two copies of the medical record are sent to the migrant nurse once the data is entered at the terminal center. Turnaround time should be no more than three weeks. Upon receiving the medical record, the nurse is to check for accuracy against the duplicate Health Data Entry Form which is in her dated pending file. Once the accuracy of the information has been verified, the duplicate Health Data Entry Form can be destroyed and the new medical record put in the student's folder.

If corrections or deletions are necessary, refer to the appropriate section of this manual for further information.

Refer to National Health Users Manual, pages 2 through 23, for an indepth discussion of the medical record output document. The output document is the medical record received from Little Rock and is not the same as the Health Data Entry Form which is the input document.

FILING SYSTEM

The need for an efficient filing system is a major priority. Each migrant nurse can use her own flexible methods, keeping in mind that as her program grows, there may be a need for changes. Feel free to contact the State migrant office and seek suggestions from other migrant nurses. The particular choice of a filing system will depend upon variables such as the number of students, the space available, coordination with the educational program, and the like. Remember, documentation is the primary tool for the evaluation of your performance, and a confidential and practical filing system is an important element in this process.

Nurses are reminded to keep these medical records in locked files to ensure the confidentiality of all student records.

If you are a full-time migrant nurse, you must have a complete and separate file on each child which includes a folder that has the student's name and contains the most recent medical record. A pending file with duplicate copies of all work that has been sent to the terminal center must also be maintained. This is done by simply taking all duplicate copies of work mailed on a specific day, placing them in a file folder, and keeping them separate from the regular files. This method allows the nurse to keep the students' permanent file folders in order and eliminates unnecessary filing. All work sent in must be dated to determine if a call needs to be made regarding turnaround time or to locate an input document quickly if a problem arises.

STUDENTS WHO MOVE

If additional health information is received after a student has moved out of your parish, this data must be recorded on the Health Data Entry Form and sent to the terminal center. This information will be updated on the student's medical record regardless of whether he has moved to another state or parish. Remember, we are a part of a national information network, and all of the information received on a particular child is forwarded to the state in which the child is presently residing. You need only to send the information to the terminal center in Baton Rouge; it is not necessary to contact any other state or parish.

Any errors found in coding on the medical record must be corrected for students who have moved as well as on all other medical records. The only one who can correct a medical record is the parish that reported this information initially. Make sure that all of your records are correct. Remember, you are responsible for the accuracy of this information.

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CORRECTIONS AND DELETIONS

Errors found in the coding of the medical record must be corrected immediately. These corrections may only be made by the parish that reported this health data. You may not correct or delete health information submitted by any other parish or state.

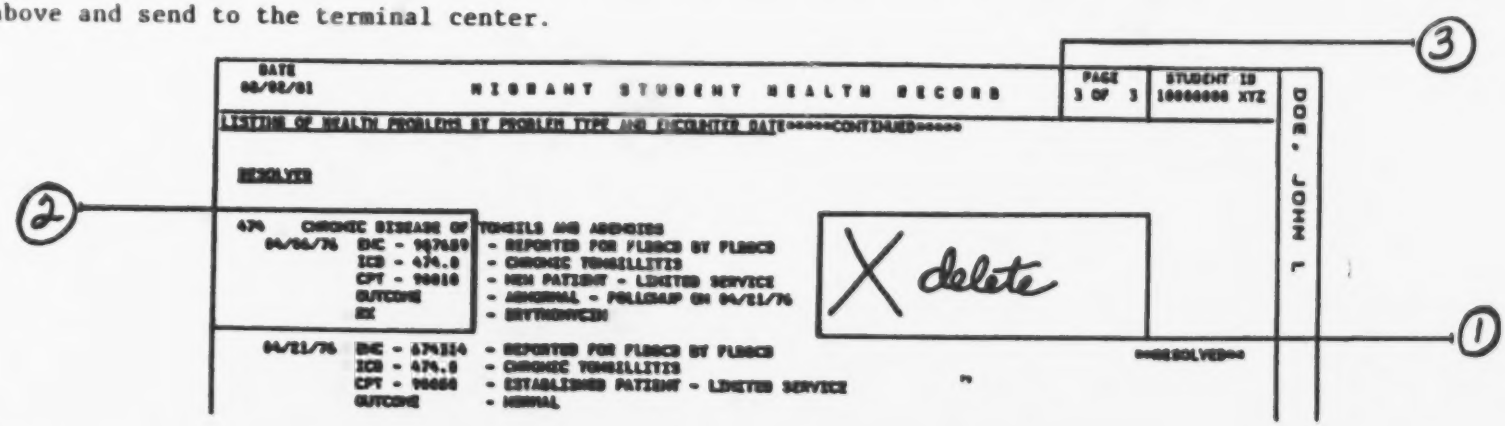
When deleting information that is already on the medical record and is found to be in error or in need of correction, follow the guidelines listed below:

1. Use red ink to mark an "X" to the right of the printed data and indicate whether the information is to be deleted or corrected.

2. Do not tamper with any code number(s). The numbers must remain legible to allow this material to be deleted by the data entry specialists.

3. Send in all pages of the medical record as the record can consist of more than one page of printed data.

When correcting information, staple a Health Data Entry Form with correct information to the above and send to the terminal center.


3
DATE
08/02/81
MIGRANT STUDENT HEALTH RECORD
PAGE
3 OF 3
STUDENT ID
10000000 XYZ
DOE, JOHN L
LISTING OF HEALTH PROBLEMS BY PROBLEM TYPE AND ENCOUNTER DATE*****CONTINUED*****
RESOLVED
2
474 CHRONIC DISEASE OF TONSILS AND ADENOIDS
04/06/76 DNC - 987659 - REPORTED FOR FLORCB BY FLORCB
ICD - 474.0 - CHRONIC TONSILLITIS
CPT - 90010 - NEW PATIENT - LIMITED SERVICE
OUTCOME - ABNORMAL - FOLLOWUP ON 04/21/76
RX - ERYTHROMYCIN
X delete
04/21/76 DNC - 674114 - REPORTED FOR FLORCB BY FLORCB
ICD - 474.0 - CHRONIC TONSILLITIS
CPT - 90664 - ESTABLISHED PATIENT - LIMITED SERVICE
OUTCOME - NORMAL
RESOLVED
1

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MEDICAL SYMBOLS

We continue to stress the importance of accuracy in reporting and submitting information. We must also emphasize that although the data entry specialists deal with medical terminology on a year-round basis, they are not familiar with our medical symbolism. Please refrain from using symbols of any kind on the Health Data Entry Form to reduce inaccuracies and telephone calls.

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SENSITIVE DATA VIA HEALTH PROBLEMS

The problem of recording sensitive data eventually presents itself to every nurse. Two examples will be shown which illustrate discretion in the recording of these problems.

Problem #1: A student is involved in a child abuse and neglect situation.

Rationale: The area of child abuse and neglect has no ICD code number. Because of the sensitive nature of this subject, the observed signs of malnutrition are indicated as the primary problem. During investigation of the malnutrition, the abuse and neglect were discovered.

HEALTH PROBLEMS

PRIMARY (1)	ICD CODE (2)	TYPE (3)	STATUS (4)	EN CODES	CPT (5)	A/N/U (6)	OUTCOME (7)	RX OR BATCH #
X	269.9	C	U		90760	U	SENSITIVE DATA-CONTACT	MIGRANT NURSE

Solution:

1. An "X" must be placed in the Primary column.
2. The "observed" sign or symptom is used as the problem and the respective ICD code used. In this case, the ICD code for malnutrition is 269.9 and is entered in the ICD column.
3. Type is coded as "C" to indicate a chronic condition.
4. Status is indicated as "U" for an unresolved problem.
5. The 90760 CPT default code is used because it indicates the student's age.
6. A "U" is placed in the A/N/U column.
7. Provide a brief message such as "sensitive data - contact migrant nurse." Remember only 39 characters are allowed in this column.

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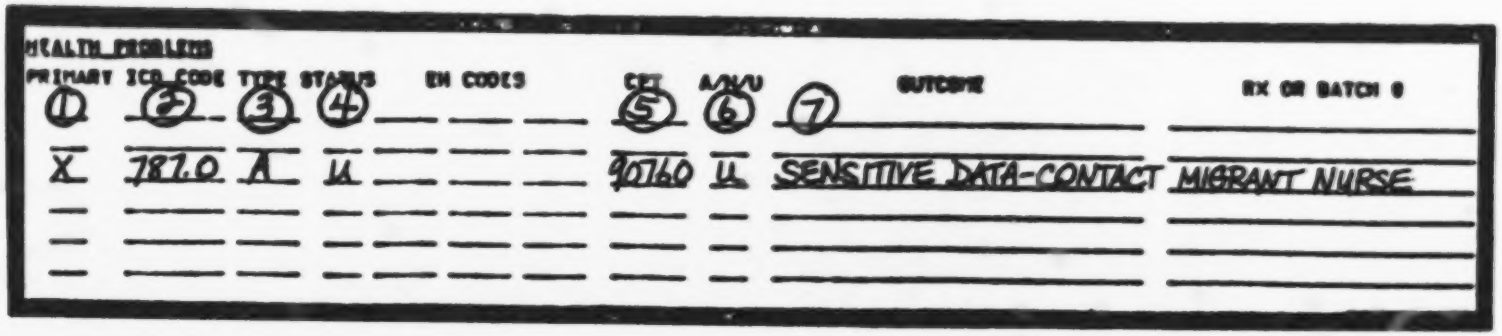
SENSITIVE DATA VIA HEALTH PROBLEMS

Problem #2: An unmarried, high school student is diagnosed as being pregnant after sudden and repeated episodes of nausea and vomiting during school.

Rationale: Pregnancy of unmarried teens carries with it a certain stigma, and some nurses feel reluctant to attach such a "label" to the student by having this appear on the medical record. Many students share this information with the migrant nurse as "confidential, priviledged information" and never intend for it to be recorded anywhere.



Solution:

1. An "X" must be placed in the Primary column.
2. The "observed" sign or symptom is used as the problem and the appropriate ICD code used which, in this case, is 787.0 for nausea and vomiting.
3. Type is coded as "A" for an acute condition.
4. Status is reported as "U" for unresolved.
5. Default code 90760 is used in the CPT column.
6. Place a "U" in the A/N/U column.
7. A brief message such as "sensitive data - contact migrant nurse" is indicated. Remember that only 39 characters are allowed in this column.

SENSITIVE DATA VIA HEALTH PROBLEMS

For other sensitive data such as alcoholism, drug dependency, and any other "priviledged information," always use the 90760 default CPT code and in the outcome column indicate a contact person for more specific information. A name, address, and phone number are not necessary because the computer will automatically print this information on the medical record with the corresponding short ID of the state and parish providing the information.

HELP!!!

When a questions arises, please call the State migrant office collect at 504+342-3521 or 504+342-4151 Monday through Friday during regular working hours.

Guessing causes many unnecessary problems and delays.

REMEMBER, IF YOU DON'T CALL US, WE'LL CALL YOU!!!

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Reference and Resource Materials

MIGRANT NURSE DIRECTORY

PARISH	NAME	ADDRESS	PHONE
Allen	Leslie June Beassie	Post Office Drawer C Oberlin 70655	318+639-2977
Avoyelles	Chris Brewer	201 Tunica Drive West Marksville 71351	318+346-2994 Ext. 244
Caldwell	Judy Mann	Post Office Box 128 Columbia 71418	318+649-6181
Delta CAA	Myra Rodden	Post Office Drawer 352 Tallulah 71282	318+574-0732
Desoto	June Webb	Post Office Box 975 Mansfield 71052	318+872-1198
Evangeline CAA	Nina Ortego	403 West Magnolia Street Ville Platte 70586	318+363-4552
Grant	Christine Harrison	Post Office Box 208 Colfax 71417	318+627-5974
Iberville	Vickie Crow Shirley Bickham Dot Griffon Jerry Orcino Josie Vicknair	Post Office Box 151 Plaquemine 70764	504+687-7626 504+344-3650
Jackson	Rebecca Surber	Post Office Box 705 Jonesboro 71251	318+259-4456
Jefferson Davis	Lorraine Bertrand Lorene Richard	Post Office Box 640 Jennings 70546	318+824-1834

MIGRANT NURSE DIRECTORY

PARISH	NAME	ADDRESS	PHONE
LaSalle CAA	Lilly Book	1402 Fourth Street Jonesville 71343	318+339-9500
Morehouse	Johnnie Lang Virgina Boddie	Post Office Box 872 Bastrop 71220	318+281-8777
Natchitoches	Gayle Lindsey	Post Office Box 16 Natchitoches 71457	318+352-8380
Orleans	Agnes Harewood	1619 Leonidas Street New Orleans 70118	504+865-7337 or 865-7338
Ouachita	Rita Caldwell	800 Claiborne Street West Monroe 71291	318+325-0451
Rapides	Fran Dowdy	Post Office Box 1230 Alexandria 71301	318+442-8321
Sabine	Brenda Anderson	Post Office Box 1153 Many 71449	318+256-9228
St. Landry	Gailia Batiste	Post Office Box 310 Opelousas 70570	318+948-3657
St. Martin	Theresa LeVasseur	111 Courville Street Breaux Bridge 70517	318+332-2105
St. Mary	Mary Lagrange Catherine Guillory Marie Dupree	Post Office Drawer 580 Franklin 70538	318+828-0552

MIGRANT NURSE DIRECTORY

PARISH	NAME	ADDRESS	PHONE
Tangipahoa	Beth Powell	305 West Hanson Hammond 70401	504+542-7290
Tensas	Mary Cannon	Post Office Box 318 St. Joseph 71366	318+766-4314
Union CAA	Floriene Kelley	Post Office Box 520 Farmerville 71241	318+368-9606
West Carroll	Martha Harper	Post Office Box 109 Oak Grove 71263	318+428-4215

PARISH SHORT ID'S

LACZCX - ACADIA
LACWYZ - ALLEN
LACXWS - ASCENSION
LACXTP - ASSUMPTION
LACPVK - AVOYELLES
LACXLW - BEAUREGARD
LACWNF - BIENVILLE
LADCDW - BOGALUSA (CITY OF)
LACVTL - BOSSIER
LACVXY - CADDO
LACRKB - CALCASIEU
LACLVT - CALDWELL
LACLWL - CAMERON
LACYFW - CLAIBORNE
LACVXZ - DESOTO
LACVXW - EAST BATON ROUGE
LACPMC - EAST CARROLL
LACXTQ - EAST FELICIANA
LABZVY - EVANGELINE
LACYMY - FRANKLIN
LACYDX - GRANT
LACRJN - IBERIA
LACPMB - IBERVILLE
LACXHW - JACKSON
LACSYY - JEFFERSON
LACVNR - JEFFERSON DAVIS
LACRKC - LAFAYETTE
LACVTH - LAFOURCHE
LABZVZ - LASALLE
LACWGP - LINCOLN
LACXFQ - LIVINGSTON
LACXHX - MADISON
LADNBJ - MONROE (CITY OF)
LACPLZ - MOREHOUSE
LACVYL - NATCHITOCHES
LACRKN - ORLEANS
LACNYZ - OUACHITA
LACQSS - PLAQUEMINES
LACVKQ - POINTE COUPEE
LACLVZ - RAPIDES
LACWGL - RED RIVER
LABKXF - RICHLAND
LACWCM - SABINE
LACVXF - ST. CHARLES
LACPPQ - ST. HELENA
LADBTR - ST. JAMES
LACWYY - ST. JOHN
LABKXK - ST. LANDRY
LABYMD - ST. MARTIN
LACPVJ - ST. MARY
LACWDR - ST. TAMMANY
LABKXL - TANGIPAHOA
LABXMC - TENSAS
LACRJY - TERREBONNE
LACRJP - UNION
LACRJZ - VERMILION
LACVRK - VERNON
LACWYX - WASHINGTON
LACZMY - WEBSTER
LACVSH - WEST BATON ROUGE
LABYLX - WEST CARROLL
LACXVD - WEST FELICIANA
LACZKM - WINN
LABKWW - STATE OFFICE

ORDERING INFORMATION

INTERNATIONAL CLASSIFICATION OF DISEASES

ICD-9-CM
Edward Brothers
Post Office Box 991
Ann Arbor, Michigan 48106

Phone 313+769-6511

Volume I (numerical)
Volume II (alphabetical)

A two volume set costs $33.00 (softbound) or $38.00 (hardbound).
A single volume costs $18.25, and you must specify the volume desired.
Prepaid orders only. Allow two to three weeks for delivery.
Make checks payable to ICD-9-CM.

CURRENT PROCEDURAL TERMINOLOGY

CPT-4, Order Department
American Medical Association
Post Office Box 10946
Chicago, Illinois 60610

Phone 312+751-6000

The fourth edition (one volume) costs $23.45 and will be available after October 10, 1983.
Prepaid orders only.
Make checks payable to the American Medical Association.

GLOSSARY

ICD (International Classification of Diseases) - a specific code number designed to describe the clinical picture of the student.

CPT (Current Procedural Terminology) - a specific code number designed to describe the treatment or services provided.

DEFAULT CODE (90760) - the CPT code that indicates a student's age. It is used when no appropriate CPT code can be located or when treatment is pending or unknown.

HEALTH DATA ENTRY FORM - the input document and the only means of reporting medical data on the student.

MEDICAL RECORD - the output document that is sent to the nurse after the data has been entered.

INPUT DOCUMENT - another name for the Health Data Entry Form.

OUTPUT DOCUMENT - another name for the medical record.

TURNAROUND TIME - The time it takes for a medical record to be received by the nurse after being submitted to the State terminal center for data entry (three weeks maximum).

APPENDIX E. DENTAL PROCEDURE CODES

Diagnostic	Code
Initial exam	D0110
Periodic exam	D0120
Emerg. exam	D0130
Diagnostic models	D0470
Diagnostic photos	D0471
Occl. analysis	D9950
Pulp test	D0460
Consultation	D9310

Radiology	Code
Complete Series	D0210
1 Periapical	D0220
Add. films	D0230
Intraoral-occlusal film	D0240
1 Bitewing film	D0270
2 Bitewings	D0272
3 Bitewings	D0273
4 Bitewings	D0274
Panoramic	D0330

Preventive	Code
Adult prophy	D1110
Child prophy	D1120
Sodium flu 4 treat exc proph	D1210
Sodium flu 4 treat inc proph	D1211
Stann flu 1 treat exc proph	D1220
Stann flu 1 treat inc proph	D1221
Dietary planing for control	D1310
Oral hygiene instr	D1330
Training-prevent-dental care	D1340
Fluoride treatment	D1230
Enamel sealants	D1350

Periodontics	Code
Subging. curet/quad	D4220
Perio scale, comp.	D4340
Perio S.P.	D4341
Occl. adj. part	D4330
Occl. adj. comp	D4331
Provisional splint	D4321
Occl. gourds	D4360
Overhang rem.	D9810

Endodontics	code
Pulp cap direct	D3110
Pulp cap indirect	D3120
Vital Pulpotomy	D3220
Root canal 1	D3310
Root canal 2	D3320
Root canal 3	D3330
Periapical surg.	D3410
Hemisection	D3920
Root amput.	D3450
Bleach	D3960
Emerg. I&D	D3990
Type 1/Gingivitis	D4500
Type 2/Early Periodontitis	D4600
Type 3/Mod Periodontitis	D4700
Type 4/Adv Periodontitis	D4800
Periodontal Prophylaxis	D4900

Oral Surgery	Code
Extraction	D7110
Add. extr.	D7120
Soft tissue imp	D7220
Partial bony imp	D7240

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